

THE BOTTOM LINE

The state must control health care costs, which are growing at an unsustainable rate.

The state should emulate the private sector and increase the share of costs borne directly by employees.

With regard to health care provided to low-income individuals, the state should prioritize services and eliminate those with the least value.

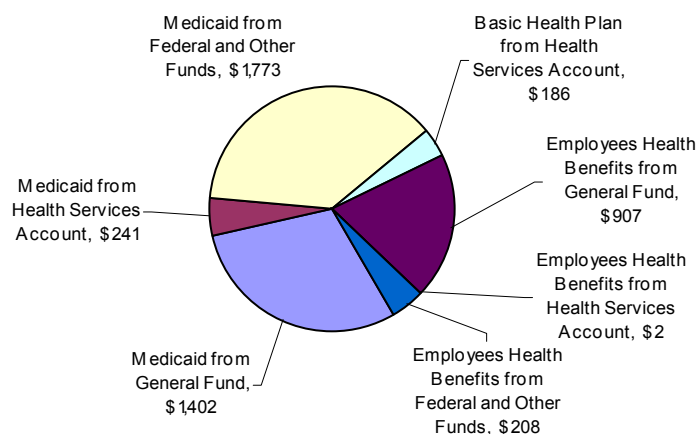
A World of Hurt: Medical Costs Squeeze State Budget

Legislators await the March revenue forecast before they begin work on the budget for the 2005-07 biennium. Current projections show a gap of \$2 billion between expenditures and available resources for the biennium. Rising health care costs account for a significant fraction of that gap.

The pressures of rising health expenditures that plague the state budget pervade the national economy. Actuaries at the Centers for Medicare and Medicaid Services calculate that national health expenditures grew from 7.0 percent of GDP in 1970 to 15.3 percent in 2003 and forecast expenditure will reach 18.7 percent of GDP in 2013 (Smith et al 2005, Heffler et al 2005). The primary force driving health care expenditures higher is technological change. The rapid rates of innovation in the health care sectors make available to health care consumers an ever-richer bounty of goods and services. (Glied 2003).

This bounty is good news, but it presents hard choices.

**Chart 1: State Health Care Spending, FY 2005
(Millions of Dollars)**



Source: OFM

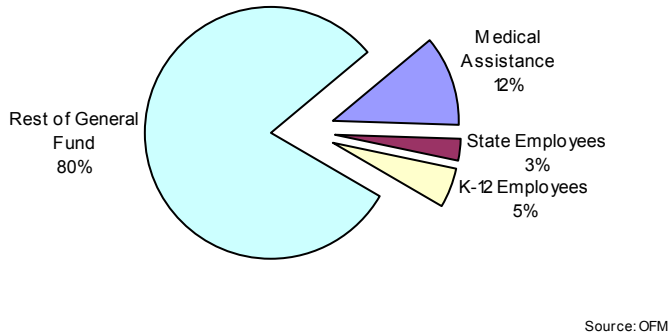
STATE SPENDING ON HEALTH CARE

Most of the state's health expenditures are concentrated in three broad areas: employee compensation, medical assistance and the basic health plan. (See chart 1.) The Office of Financial Management (OFM) projects spending on these programs for fiscal year 2005 will total \$4.7 billion. Of this, 49 percent comes from the state general fund, and 9 percent comes from the health services account. (The health services account receives revenue from the cigarette and tobacco products taxes, insurance premiums tax, liquor, beer and cider

taxes, and the B&O tax on public and not-for-profit hospitals. It also receives money from the tobacco settlement.) The remaining 42 percent of funding comes from a combination of other sources, primarily federal but also including state and local.

The \$2.3 billion flowing to health expenditures from the general fund represents 20 percent of general fund spending for FY 2005. (See chart 2.)

Chart 2: Health Care is 20 Percent of General Fund Spending for FY 2005



Health care costs are growing more rapidly than the revenues that are used to pay for them.

Health care spending from the general fund and health services account combined is expected to grow by 10.5 percent for FY 2006 and 7.1 percent for FY 2007. Growth rates like that crowd out other spending. OFM places the long run rate of growth of general fund revenues at 5 percent at current rates of inflation and population growth. The rate of growth in health services account revenue is lower, 1 to 2 percent.

Health spending is 22.1 percent of combined general fund and health

services account revenue for FY 2005, 23.9 percent for FY 2006, and 24.5 percent for FY 2007. (See Chart 3.)

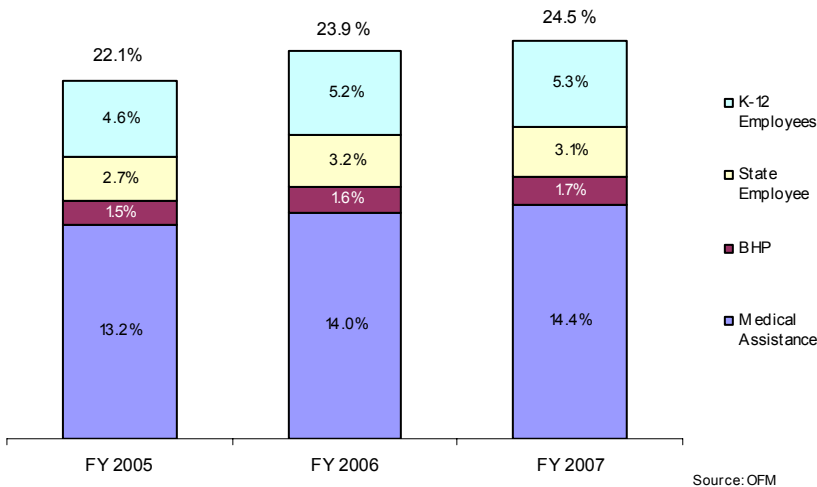
EMPLOYEE BENEFITS

The state funds health benefits for its own employees and provides money to school districts to fund the health benefits of K-12 employees.

State employees receive health care benefits through the Public Employee Benefits Board (PEBB), which is responsible for designing benefits packages and setting employee contribution rates. Under the collective bargaining agreements recently negotiated by Governor Locke, the state is to contribute \$633 per represented employee per month to PEBB in FY 2006 (a

13.4 percent increase over FY 2005) and \$744 per represented employee per month in FY 2007 (a 12.2 percent increase over FY 2006). Negotiators calculated these contribution rates assuming medical cost inflation would be 11 percent per year and that employees would share 12 percent of premium costs. However, under the contract the state contribution is fixed. If health care costs grow less than the assumed 11 percent, the share of premiums paid by employees might fall.

Chart 3: Health Care Spending as Share of General Fund and Health Services Account Revenue



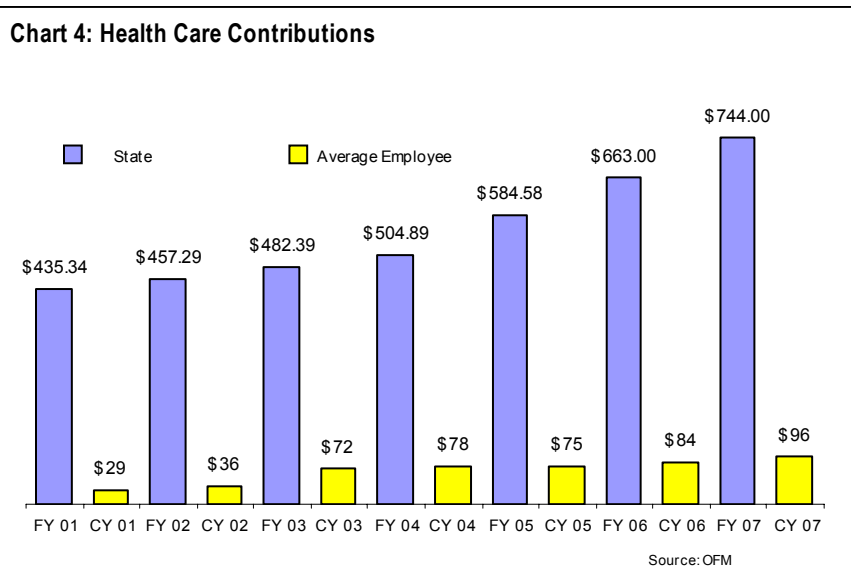
Governor Locke’s budget extended the same health benefits to state employees who are not union represented. In FY 2007 the state would

provide \$663 per non-represented employee per month to PEBB. In FY 2007 the state would contribute \$618 per month, which PEBB would supplement with \$126 per employee per month drawn from its surplus funds.

The state provides health benefit funding to school districts for K-12 employees at the average funding rate for state employees. Thus, under the

Locke proposal the state would provide school districts \$663 per employee per month in FY 2006 and \$689 per employee per month in FY 2007. (The latter number is the weighted average of the funding for represented and non-represented state employees.)

PEBB currently offers state employees a choice among eight different health care plans, although not every plan is available in every county of



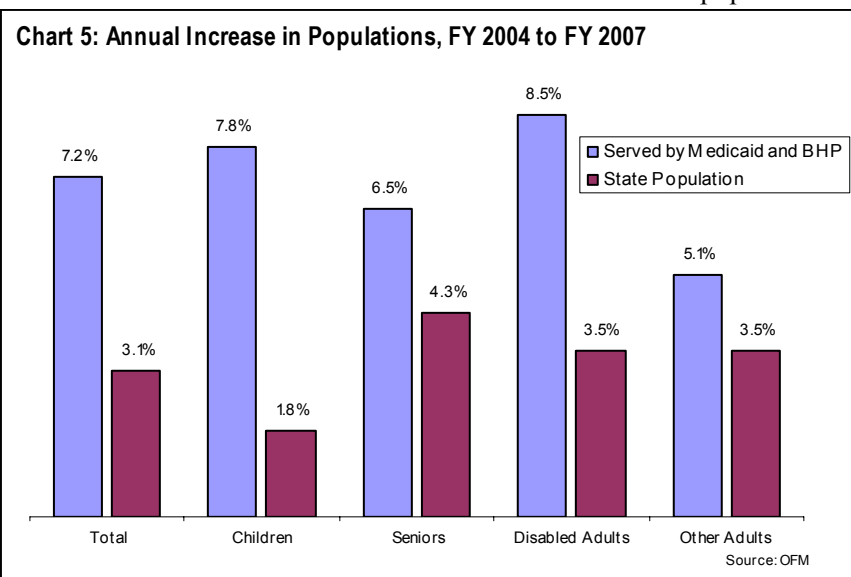
the state. Six of the eight are managed care plans and two are Preferred Provider Organizations (PPOs). Fifty-five percent of state employees are in a managed care plan while 45 percent are in a PPO. In January, 2005, 220,216 state employees and their dependents were enrolled in a plan. The most popular managed care plan, with 75,217 enrollees, was through Group Health Cooperative. The most popular PPO, with 98,116 enrollees, was the Uniform Medical Plan (UMP) PPO. UMP is a self-funded plan designed by PEBB and administered by the state Health Care Authority.

State employee health care benefits are generous. The 12 percent share of premiums paid by employees is low. A survey by the Kaiser Family Foundation and the Health Research and Educational Trust (KFF-HRET) found in 2004 the typical employee covered by employer-sponsored health insurance paid 15 percent of the cost of single coverage and 27 percent of the cost of coverage for a family of four. A Towers Perrin survey of 200 large employers found that for 2005 the average employee's share was 21 percent.

The Towers Perrin survey pegged the average monthly employer contribution per employee at \$512.50 for 2005.

MEDICAL ASSISTANCE AND THE BHP

Through medical assistance and the basic health plan, the state provides health care for 954,000 low-income residents of the state. This is 15 percent of the state's population and includes one of every three children and four of every ten pregnant women.



Medical assistance: The Department of Social and Health Services's Medical Assistance Administration provides means-tested health care to about 854,000 Washingtonians (average monthly enrollment). For most of these enrollees, state funds are matched by federal money under the Medicaid program and for this reason medical assistance is popularly referred to as Medicaid. (Note, however, that Medicaid also provides federal money for other state programs, such as long-term care and developmental disabilities.)

Federal Medicaid program rules establish certain groups of individuals that state medical assistance programs must cover and additional groups that states may elect to cover. Washington has opted-in on many of the optional coverages. (Washington Research Council 2002) Of the 854,000 Medical Assistance recipients, 230,000, over one-quarter, need not be covered under federal rules.

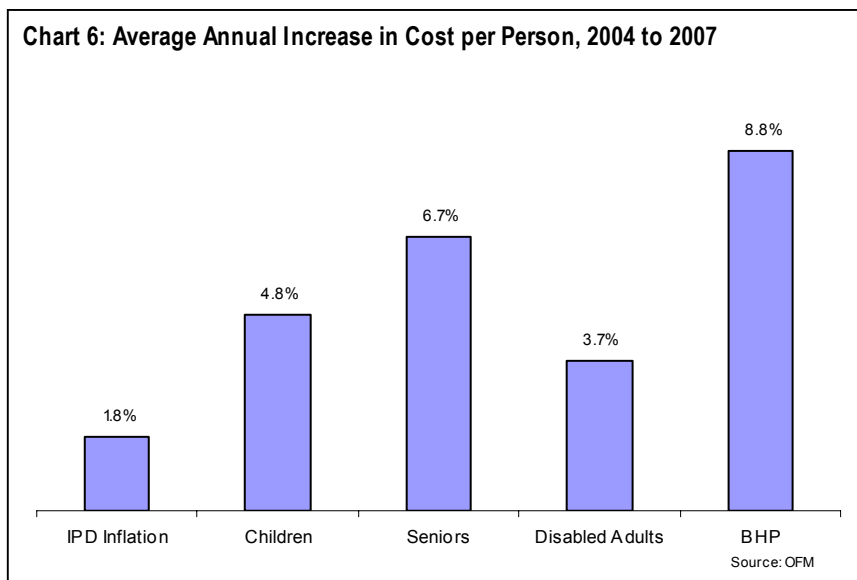
Basic health: The basic health plan (BHP) administered by the health care authority is a health insurance program that provides coverage to low-income state residents. Premiums are subsidized, the degree of subsidy varying with income. BHP began operation as a pilot program in 1988 and became permanent in 1993. The 2003 legislature placed a cap of 100,000 on regular enrollments. (In addition, about 1,400 state-funded home care workers receive health insurance through the BHP.)

Nationally, medical assistance is one area where managed care remains strong (Draper et al 2004). In Washington, most medical assistance and basic health plan recipients are served

through managed care plans.

Increasing enrollments and higher per enrollee costs both contribute to the state's costs for providing health care to low-income residents.

Between FY 2005 and FY 2007, the number of people covered by Medical Assistance and the BHP is projected to grow by 7.2 percent while state population grows by 3.1 percent. (See Chart 5.) Senate Ways and Means staff cite four reasons for the greater growth in caseloads than population; reduced dependent coverage and higher cost-sharing in employer-sponsored plans; rising medical costs increase the incentive for eligible people to enroll; longer life expectancies; and the aging of the baby boom generation.



to enroll; longer life expectancies; and the aging of the baby boom generation.

Costs per enrollee are expected to rise considerably faster than the rate of general inflation as measured by the personal consumption IPD deflator. The growth rate in the BHP is particularly high. (See chart 6.)

Overall state costs for medical assistance are expected to rise by 7.5 percent in FY 2006 and 8.1 percent in FY 2007. Costs for the BHA are to rise by 8.3 percent in FY 2006 and 9.1 percent in FY 2007.

DISCUSSION

Health Care cost increases of this magnitude are not sustainable.

With regard to employees: In the private sector, employers have increased coinsurance and copay rates to make employees more cost-conscious in their use of services. Employers are also raising the share of premiums paid by employees to make more visible the cost of the health care portion of their compensation (White 2004). The state should follow this example.

Ultimately employees must realize that increases in health benefits reduce their take-home-pay.

With regard to low-income medical care: The state faces a tradeoff between the number of individuals it covers and the depth of that coverage. The ongoing process of technological change is continually deepening coverage at the same time it drives cost up. Rather than reducing the number of individuals it covers, the state should prioritize services within the existing managed care framework.

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